US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/03/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: pump refill and follow up visit

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiologist and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for pump refill and follow up visit is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: he patient is male with chronic pain. On 11/13/14, he was seen in clinic with date of injury of xx/xx/xx. He complained of increasing low back pain with cramping into his lower extremities with pain rated 8-9/10. Previous appointment showed approximately 25% increase on the intrathecal pump. Plan was to increase the pump with the same increase from 2.798 to 3.299mg per day. He was taken MSIR 60mg as needed. The requested MRI was not performed as there was no facility that could sedate him. On exam blood pressure was 122/87 pulse rate was elevated at 110. On 11/24/14, pump was interrogated noting the daily dose rate was 3.597mg per day morphine. On exam, his morphine had been changed and pump reprogrammed with increase of daily dosage of morphine to 3.6mg per day. His personal therapy manager had also been turned on to get him up to 0.4mg of more morphine sulfate per bolus. He was due for pump refill in nine weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 01/08/15, a utilization review determination stated the requested pump refill of all follow up office visit was denied. MS dose was increased but there was no indication of benefit from this or pain reduction. On 01/21/15, a utilization review also noted adverse determination for the requested pump refill and office visit. The patient was seen on 11/24/14 with complaints of chronic low back pain and had adjustment of narcotic pain pump with reprogramming with increase of his morphine sulfate to 3.6mg per day. His personal therapy manager was also turned on that time to getting 0.40.4mg of morphine sulfate per bolus. His pain pump was not objectively documented on that progress note and there was no indication for rationale for increasing his morphine sulfate. There was no indication as to the exact date the pump was placed. The request was non-certified.

For this review, records were reviewed including 11/24/14 progress note showing the pain pump was increased from with morphine increased to 3.6mg per day and his personal manager was turned on allowing him a bolus of morphine. His pain was not objectively identified on VAS at that time. The rationale for increasing his pain pump at that time was not provided by the provider was not documented by the provider. Guidelines indicate that a programming sessions which may occur along with or independent of refill sessions allows the clinician to adjust the prescription and record or recall important information about the prescription. The clinical documentation submitted for review does not include the rationale for refill with increase to 3.6mg morphine a day plus a bolus. It is the opinion of this reviewer that the request for pump refill and follow up visit is not medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)